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CHILD ABUSE AND NEGLECT BY PARENTS WITH DISABILITIES: A TALE OF TWO FAMILIES

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Two families, in which the children had been placed in foster care due to abuse and neglect by parents who had disabilities, were studied. In the first case, the mother was instructed in skills that our assessment suggested were important for her child's survival. The mother readily acquired and applied these skills, a fact reflected both in changes in her behavior and in changes in the child's well-being. In the second case, the parent's incremental resumption of child custody was made contingent upon completion of relevant parenting tasks. Initially, improvements in the completion of such tasks were evident, but over time and with the onset of militating factors, no further progress was made and all parental rights were terminated. The implications of these cases for behavior analysis and the effort to reunite and preserve families are discussed.

DESCRIPTORS: child welfare and neglect, parent training, mentally retarded parents, family preservation

Extreme opinions are often held about the competence of parents with developmental and other disabilities, especially mental retardation. At one extreme, such parents are presumed to be incapable of providing minimally adequate care for their children. At the other, any question whatsoever about the competence of parents with disabilities to care for their children is met with indignation and outrage. Therefore, when these parents perpetrate child abuse and neglect, the debate over their rights versus their competence to raise children is often particularly acrimonious.

The resolution of child abuse and neglect cases involves caseworkers, service providers, juvenile or family courts, and attorneys for the state, parent, and child. Their collective actions are supposed to be guided by a complex, and sometimes conflicting, mix of federal and state (and sometimes county) law and regulations. However, some overarching principles are articulated in P.L. 96-272 (the Adoption Assistance and Child Welfare Act of 1980), which expresses a preference for preserving the natural family and, in cases of child abuse and neglect, requires states to make "reasonable efforts" to avoid placing the child out of the home. If such placement is unavoidable, the state must then make similar efforts to reunite the family. Although not precisely defined in law, "reasonable efforts" generally include services such as counseling, parent training, cash assistance, and housing assistance (National Council of Juvenile and Family Court Judges, Child Welfare League of America, Youth Law Center, National Center for Youth Law, 1987).

There is growing evidence that the competence of parents with mental retardation can be improved with training. For example, studies have addressed the development of specific skills such as problem solving (Tymchuk, Andron, & Rahbar, 1988), responding to emergencies (Tymchuk, Hamada, Andron, & Anderson, 1990), the physical care of infants (Feldman et al., 1992), infant stimulation and responsiveness (Feldman, Case, Rincover, Towns, & Betel, 1989; Feldman et al., 1986), and menu planning (Sarber, Halasz, Messmer, Bickett, & Lutz-

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ker, 1983). The evidence from these and related studies supports the contention that important child care skills of some parents with developmental delays can be corrected with training.

However, there are limitations to the research. In some cases, critical parenting skills have been trained and assessed only in simulation (e.g., Tymchuk et al., 1988, 1990), and in nearly every study only a very limited set of the numerous skills required for minimally adequate parenting were assessed or taught. In addition, most research has involved parents who apparently had no serious involvement with the child welfare system (e.g., adjudication for child abuse and neglect or placement of the children into foster care). Indeed, studies often report that "child abuse was not suspected," only that the parents were "being monitored" by service agencies (Feldman et al., 1989, p. 212). Thus, there is a need for research that contributes to the effort to develop the competence of mentally retarded parents in families at imminent risk for dissolution because of child abuse and neglect.

Such research is necessary, first because parents with a history of child abuse may be less responsive to training than parents without such a history. Second, systematic attempts to assess and enhance the skills of this population through a behavioral technology may improve our understanding both of the limits to that technology and of the broader environmental changes that may be necessary to sustain families at risk for dissolution. That is, training alone may not be sufficient to preserve families if their poor socioeconomic circumstances need to be alleviated with ongoing financial, social, and legal support (Tymchuk, 1990). Third, reporting the nature and results of intensive training in the literature can add to the body of information that courts and social service agencies can use to judge what constitutes "reasonable efforts" to preserve families.

These points are illustrated in the following studies of two different families. Both had a history of abuse or neglect, both were headed by parents with mental retardation, both had at least one child involuntarily placed in foster care, and both faced the distinct possibility of having parental rights terminated.

STUDY 1

METHOD

Participants

The participants were a family consisting of Christine, a 22-year-old mother, and her son John, 5 weeks old. Records of Illinois' child protective agency, the Department of Children and Family Services (DCFS), indicated that Christine had been physically and sexually abused by her biological parents until she was 2 years old. Their parental rights were terminated and Christine lived with an aunt and subsequently a foster family for 2 years before being adopted by another family at 4 years of age.

Prior to John's birth, Christine had been employed at a sheltered workshop for developmentally disabled adults and received income from the supplemental security program. Her IQ, according to recent psychological reports on record with DCFS, was 71. She had completed the 9th grade of special education. Christine's involvement with DCFS began at the midterm of her pregnancy when the agency provided transportation to prenatal health care appointments.

John weighed 6 lb 2 oz at birth and 5 lb 10 oz at discharge. According to DCFS records, Christine's physician reported that her umbilical cord had a narrow diameter with a small placenta, indicating poor prenatal nutrition. Within 1 week of delivery, John weighed 5 lb 5 oz, at which time he was hospitalized for failure to thrive. He was discharged 5 days later at 5 lb 7 oz. Nine days later he was rehospitalized due to failure to thrive with a weight of 5 lb 9 oz; he was discharged after 1 week weighing 6 lb 4 oz, at age 1 month.

Upon this second discharge, Christine consented to John's placement in foster care. They visited in their own home for approximately 2

hr, twice per week. Within 11 days, Christine requested that foster care services be terminated. However, DCFS obtained a court order for John's continued foster placement. During a subsequent court hearing, Christine was cited for neglect in John's failure to thrive. The court ordered DCFS to assume guardianship for the ensuing year and to continue John's placement in foster care.

At 3 months of age, while in foster care, John had surgery for a hernia. At 5 months, John was assessed by a birth-to-three program that began providing physical therapy at home for gross motor delays. At 15 months, he began to attend the program 2 days per week.

Setting

DCFS referred the case to Project 12-Ways when John was 5 weeks old and was residing in a foster home. Project 12-Ways operates under the auspices of the Behavior Analysis and Therapy Program at Southern Illinois University and provides in-home parent training to families with a history of child abuse and neglect (Lutzker, Frame, & Rice, 1982). All services were provided when John visited Christine at her residence in a small, rural midwestern town. Sessions lasting about 60 min were typically conducted once or twice per week by staff who were graduate students or graduates (with master's degrees) in behavior analysis.

Materials

Materials used for assessment and training included diapers, bottles, a thermometer, an anatomically correct infant doll, child toys, home safety supplies (e.g., outlet plugs, safety latches), publications illustrating the food groups and recommended serving sizes, and an instructional manual for parents to identify illnesses and to apply or seek appropriate treatment (Delgado & Lutzker, 1988).

Target Behaviors and Measurement

Our selection of target behaviors and formulation of intervention strategies were based on a preliminary assessment that included (a) careful review of DCFS and hospital records describing the family's history and instances of John's failure to thrive, (b) DCFS's case plan which outlined obstacles to the family's reunification with reference to what DCFS considers "minimum parenting standards" (Illinois Department of Children and Family Services, 1985; these standards are not quantified or behaviorally defined, but provide guidelines for state authorities to judge whether or not parenting is adequate in areas of child care such as providing "the quantity and quality of food necessary to assure adequate health and development" and "ability to educate the child in social interaction skills"), (c) discussion with social service agents involved with Christine, and (d) informal observations of Christine attempting to care for John. Based on this preliminary assessment, it appeared that Christine had never acquired the skills of basic child care. Accordingly, target behaviors and intervention strategies were developed on the assumption that if Christine could acquire an adequate repertoire of child care skills, the family might be reunited and preserved.

In addition, because of the rapid behavioral changes associated with John's development and maturation, the approach to assessment and training required flexibility. For example, in the initial phases of service we targeted the critical skills of infant care such as diapering, bathing, feeding, temperature taking, and soothing. As John developed, however, Christine was expected to acquire variations or extensions of these skills (e.g., menu planning, recognizing illness, responsive play, and behavior management). Accordingly, the assessment and training of skills targeted in this study were conceptualized within two major categories: insuring immediate survival and planning ahead. The scope and sequence of training are illustrated in Figure 1.

Assessment for purposes of baseline and determining the effects of training involved a combination of knowledge (written tests) and performance measures. Performance was mea-

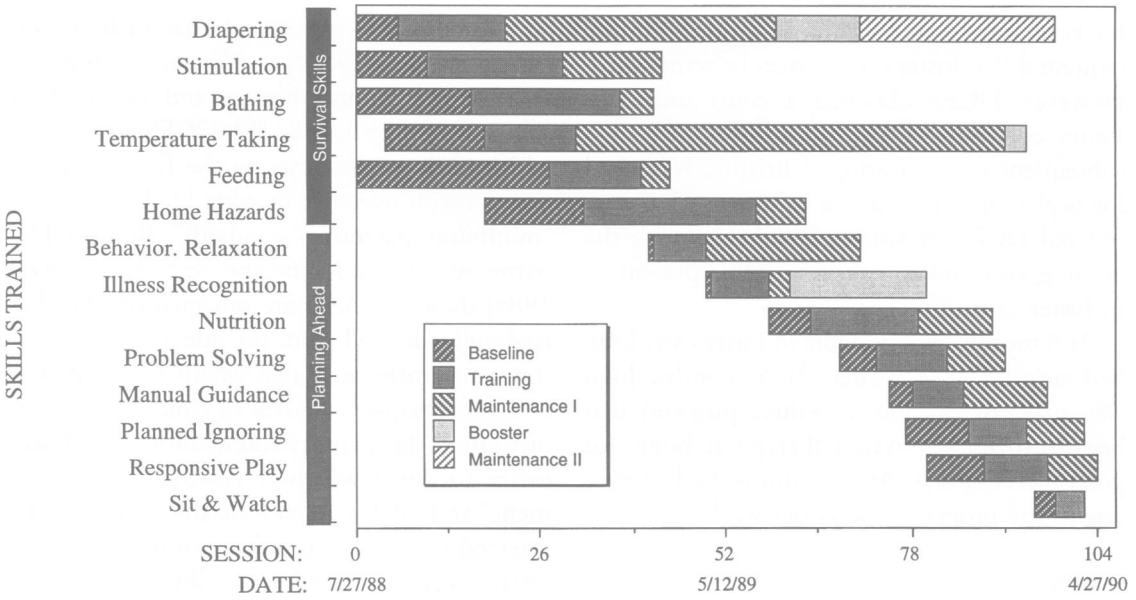

Figure 1. Scope and sequence of behavioral intervention over the course of approximately 1.5 years of service.

sured based on task analyses (diapering, bathing, feeding, temperature taking, manual guidance, planned ignoring, sit-and-watch), interval observation and recording systems (parental stimulation, responsive play), and published assessment protocols. The published protocols measured home hazards (Tertinger, Greene, & Lutzker, 1984), behavioral relaxation (Poppen, 1989), and problem-solving ability (Borck & Fawcett, 1982). Finally, when John began to eat regular food, Christine recorded on a "tracker" form the amount of each food item she served (in cups or portions of a cup). These trackers were retrieved and replaced weekly by the staff and used to determine the proportion (either a correct, excessive, or deficient proportion) of the recommended daily allowance that Christine served (portions of the definitions of each target skill and the manner in which they were measured are outlined in Table 1).

Observer Training and Reliability

Observers were graduate students in the Behavior Analysis and Therapy Program who comprised the staff of Project 12-Ways. Training in the use of the assessment protocols was required for employment on the project. Sessions with Christine and John were typically conducted by two staff members. Thus, it was possible to assess interobserver agreement for most behaviors throughout all phases of service.

For task-analyzed behaviors (e.g., diapering), an agreement consisted of those steps that had been scored identically by the observers. For interval data, agreements consisted of intervals in which both observers agreed on the presence of the behavior; disagreements consisted of intervals in which one scored the presence of the behavior and the other did not. A percentage of interobserver agreement on the Home Accident Prevention Inventory (HAPI), used to measure safety hazards, was based on the ratio of the smaller number of hazards scored by one observer to the larger number scored by the other (Tertinger et al., 1984). Finally, agreement on the extent to which Christine's meal planning matched her meal preparation was determined by comparing the menus she planned in the staff member's presence to those she reported serving on the routine tracker. Mean interobserver agreement percentages for all behaviors and all phases was 84%. Mean agreement

was never less than 70% during any condition for any particular behavior except two (parental instructions and infant response), and these were primarily associated with very low occurrences.

Experimental Procedures

Baseline. During baseline, Christine's skill proficiency in the target areas was typically assessed during the time the pertinent routine normally occurred. Staff simply observed Christine at those times and provided no intervention unless harm to John appeared to be imminent (e.g., heating the formula excessively). When written tests were part of the assessment protocol, these were typically administered during the last day of baseline.

Standard training. Training followed a similar format with each skill area. Staff provided a simple instructional text with illustrative diagrams, reviewed the material with Christine, explained the importance of executing a task in a particular way, demonstrated the task, and asked Christine to perform the task. Staff praised Christine for completing steps successfully and provided corrective instruction for incorrect or omitted steps. Training continued in this manner until Christine could complete, for most skills, 100% of the steps without assistance on three consecutive observations.

Maintenance. During maintenance no prompts or reminders were provided prior to Christine's attempt to perform the task; upon completion, her performance was reviewed. If it had deteriorated to below 80%, booster training was given in the same manner as standard training.

Particular Variations in Assessment and Training

Use of simulations and role play. On the first day that Christine was taught to use gentle, rhythmic rocking movement to soothe John, an infant doll was used to avoid the possibility of upsetting John in the early stages of Christine's skill acquisition. A doll was also used on the first day in which Christine was taught how to take his temperature.

Using an illness recognition protocol (Delgado & Lutzker, 1988), Christine was asked to pretend that John had certain symptoms that the staff described. Christine was asked to role play the action she would take while the staff member played the parts of John and medical personnel. On one occasion, however, John was ill during one of the sessions, thus providing the opportunity for an assessment of actual performance.

In addition, the management of John's behavior, in part due to his young age, had not become a significant concern during the period of our involvement. Thus, there were few opportunities for in situ assessment and training of the child management skills (manual guidance, planned ignoring, and time-out or sit-and-watch). Therefore, these skills were assessed and trained partly in situ and partly with role playing.

Experimental Design

Over the course of service, 15 skills were trained according to the sequence outlined in Figure 1, affording the opportunity for a multiple baseline or multiprobe evaluation of the training of several skills.

Results

Figure 2 depicts Christine's performance on 10 of the 15 skills necessary for day-to-day survival and planning ahead for the care of John. (The skill sample and Christine's performance are representative of all 15 skills.) Table 2 presents her mean level of performance on all skills during each condition. In general, Christine gained and maintained proficiency with a particular skill after about three to seven training sessions. However, brief booster sessions were necessary for diapering, temperature taking, and illness recognition. For some skills, the effects on John were evident (Figure 2). For example, as Christine's stimulation changed from negative (e.g., abrupt bouncing) to positive (gentle

Table 1
Target Skills, Sample Measurement Items (of Knowledge and Performance), and Context for Measuring Performance

Skill	Sample written tests			Sample task analysis steps or target behaviors	Assessment context
Diapering	T	F	You should always sprinkle powder in your hand first, before applying it to baby.	Pats area dry after washing.	In situ
	T	F	Diaper rash is never serious, so even if your baby has it more than 3 days, there is no need to call the doctor.	Treats diaper rash if present.	
Bathing	T	F	It is okay to check the temperature of baby's bath water by just sticking your hand in it.	Checks temperature of water with elbow or wrist before placing baby in it.	In situ
	T	F	Two or three baths a week are plenty for an infant.	Washes face with clean cloth before washing other parts of baby's body.	
Temperature taking	T	F	When taking your baby's temperature under the arm, you must hold it in place 3 or 4 minutes.	Shakes thermometer below 96°.	In situ and role play
	T	F	A temperature reading taken under the arm is about a degree lower than the baby's actual temperature.	Holds thermometer in place at least 3 minutes.	
Feeding	T	F	All feeding supplies should be washed thoroughly with hot, soapy water.	Burps baby halfway through bottle.	In situ
	T	F	Doctors recommend putting a little cereal in a baby's bottle	Presents spoon from the front.	
Parent-infant stimulation				Parental positive (gentle rocking, humming) Parental negative (quick jostling, ridicule, yelling)[a] Child positive (babble, coo) Child negative (cry, grimace)[a]	In situ
Safety				Accessible ingestible objects, fire hazards.[a]	In situ
Behavior relaxation training				Head is motionless and supported with nose in midline with body. Both shoulders appear rounded and transect same horizontal plane.	In situ
Illness	T	F	You should stop giving medicine to a child as soon as she feels better.	Note general symptoms of illness that are present. Finds treatment recommended in illness reference.	Role play
Balanced meal planning				Amount and type of food served (recorded by Christine).	
Problem solving				Define problem. List solutions. Make plan.	Role play

Table 1
(*Continued*)

Skill	Sample task analysis steps or target behaviors	Assessment context
Manual guidance	Gently take child's hand and guide to perform task. Thank child for performing task.	In situ
Planned ignoring	Parent turns away from child 45°. Parent doesn't argue with child.	In situ and role play
Sit-and-watch	Give warning after first occurrence of aggression. Least physical or verbal interaction while escorting to chair.	Role play
Responsive play	Instructions,[a] verbals, touch, praise	In situ

[a] Behaviors or conditions targeted for reduction.

rocking, gentle talking), John babbled or laughed more and cried less.

Figure 3 depicts the proportion of the recommended daily allowance from each food group that Christine prepared and served to John. Initially, Christine served either an excessive or a deficient proportion. With training, however, she regularly served at or near the desired proportion. The benefits of proper nutrition were evident in John's weight. Figure 4 depicts his weight and the percentile ranks of his weight at various chronological ages. In the initial weeks of his life, his failure to thrive was evident in both his low weight and the percentile rank of that weight. By age 7 months (or approximately 6 months into service) John weighed nearly 25 lb, slightly more than average for his age group. By the end of service, his weight was near the median for his age.

Finally, as Christine acquired greater parenting competence, the child welfare agency granted her longer periods of time with John (Figure 5). Initially, these periods were brief (1 to 2 hr per week) and were supervised. Gradually, however, John was left in her custody for greater periods without supervision until, after a period of more than a year in service, he spent his first night in Christine's home. She was granted full custody of John 3 months later. Christine and John have since lived together as a family with no other reports of harm or intervention by DCFS.

Discussion

Training in the basic skills of child care and day-to-day management appeared to be instrumental in effecting the reunification of Christine and John. Although there have been no subsequent indications of the need for additional services, such services may eventually be necessary. For example, although a parent may learn and apply the basic skills necessary to care for a child in the first few years of life, there may be milestones in the child's development that require further parent training. Toilet training, the development of language, and the beginning of social relationships outside of the home may present the parent with challenges that require additional parenting skills. Finally, there may be some cases in which training alone is insufficient to achieve competent parenting. An analysis of the family's individual circum-

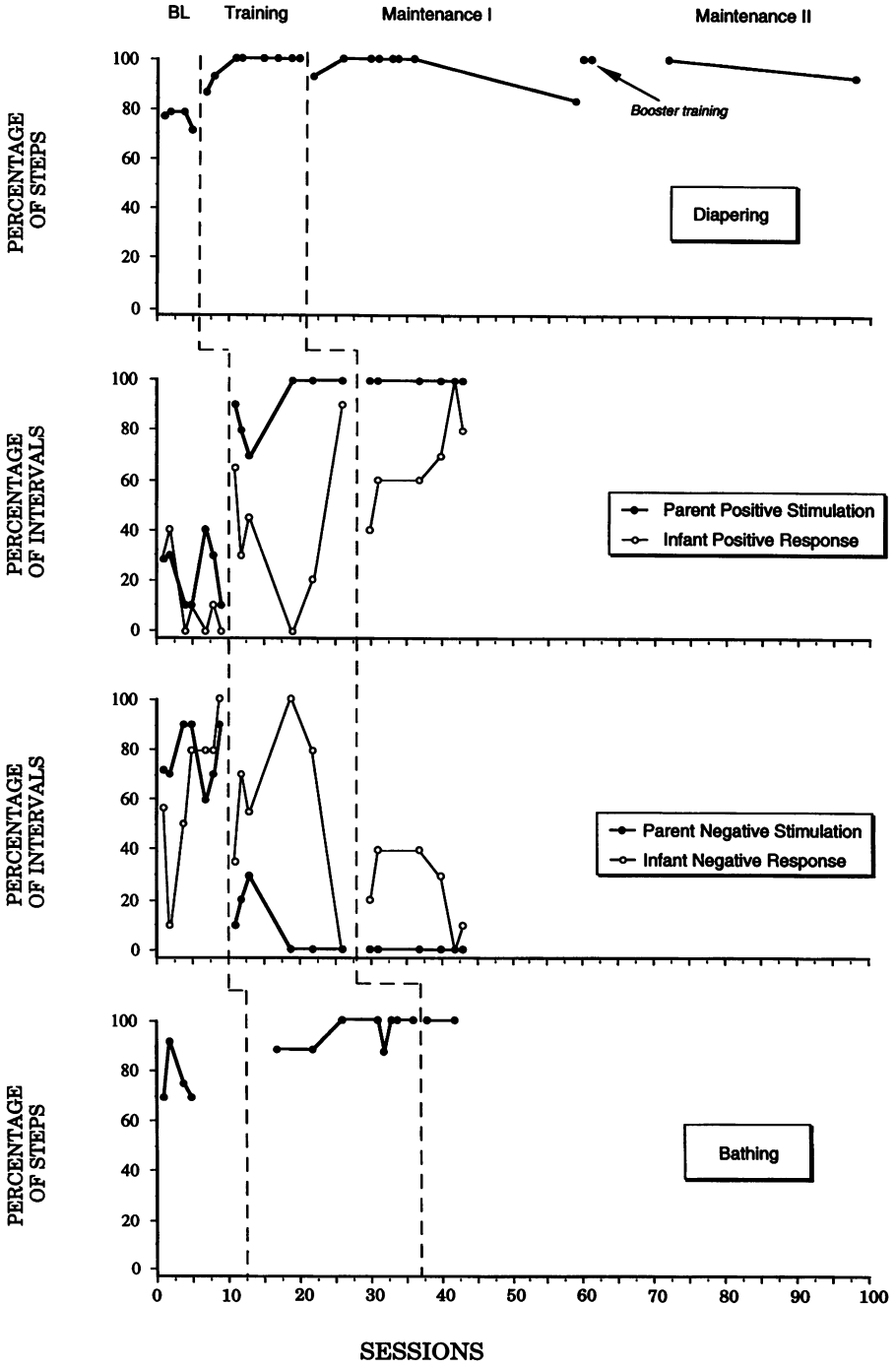

Figure 2. Christine's performance on a sample of the skills involved in day-to-day survival and planning ahead for the care of John during baseline, training, and maintenance phases. In some cases, John's behavior in response to Christine's use of skills is represented (e.g., infant positive and negative response).

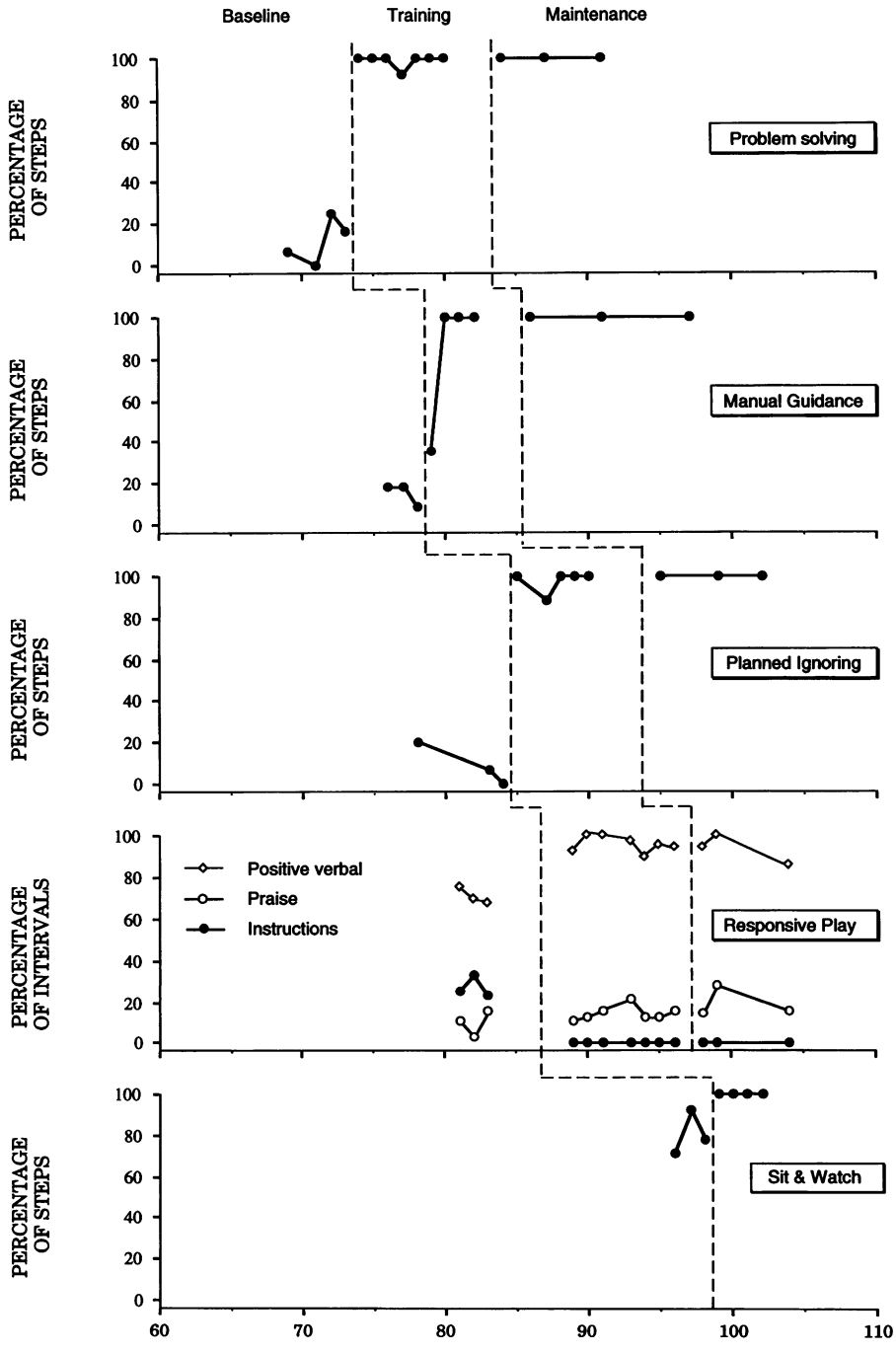

Figure 2. Continued.

Table 2
Mean Percentage of Performance Per Skill Per Condition

Skill	Baseline	Training	Maintenance 1	Booster	Maintenance 2
Diapering	76	97	97	100	100
Bathing	76	95	100		
Temperature taking	25	98	92	100	
Feeding	60	94	100		
Parent positive stimulation	23	90	100		
Parent negative stimulation[a]	77	10	0		
Infant positive response	13	96	68		
Infant negative response[a]	65	56	23		
Home hazards[a]	11	0	2		
Behavior relaxation	6	98	98		
Illness recognition	22	97	52	95	100
Problem solving	12	99	100		
Manual guidance	15	84	100		
Planned ignoring	9	98	100		
Sit-and-watch	80	100			
Responsive play					
Instructions[a]	27	0	0		
Positive verbals	71	96	94		
Praise	10	15	20		

[a] Behaviors or conditions targeted for reduction.

stances may suggest the need for additional contingencies to encourage parents to acquire and apply appropriate child care skills. However, some of these contingencies can be difficult for the treatment specialist either to identify or to arrange. The second study is illustrative.

STUDY 2

METHOD

Participants

The participants were a mother, Tricia, her 2 children—Craig (23 months old) and Janet (8 years old)—and Tricia's paramour, Malcolm. The 2 children had resided in foster care for 18 months prior to the study. Their placement was precipitated by the biological father's sexual abuse of Janet. In addition, the father, whose IQ was 64 according to psychological reports available from DCFS, perpetrated at least three other incidents of abuse involving both children over a period of 2 years prior to the study. Tricia and the father were separated and eventually divorced during the period of service. However, Tricia also had been cited by the court for failure to protect the children from the harm the father had inflicted. In addition, DCFS and the court cited other reasons for maintaining the children in foster care, including the filthy and hazardous condition of Tricia's home and questions about her and Malcolm's ability to supervise and care for the children.

According to psychological records with DCFS, Tricia's IQ was 75. She had been physically and sexually abused by her stepfather. She had graduated from high school (special education) and had occasionally worked at a sheltered workshop for persons with developmental disabilities, but was unemployed throughout the period of the study. Malcolm was also unemployed. His IQ was not known; however, he had also been served by the sheltered workshop. The family's income was derived entirely from various forms of public assistance. During the period of service, Malcolm and Tricia gave birth to another child, Pete.

Setting and Assessment

Sessions were typically conducted once or twice per week during visits with the children at Tricia's and Malcolm's residence, a mobile home. Although Tricia was expected to serve the children a nutritious snack or meal during these visits, she was never observed to do so. The residence was dirty, infested with roaches, strewn with clothing and accumulated garbage, occasionally lacked heat and adequate plumbing, and presented numerous hazards. Some of the hazards in the home were structural (e.g., a malfunctioning gas stove); others were readily correctable (e.g., by securing sharp and ingestible objects). In the course of service, Tricia and Malcolm moved to a more structurally sound mobile home.

Our preliminary assessment and formulation of intervention strategies began, as in Study 1, with a review of records, interviews with social

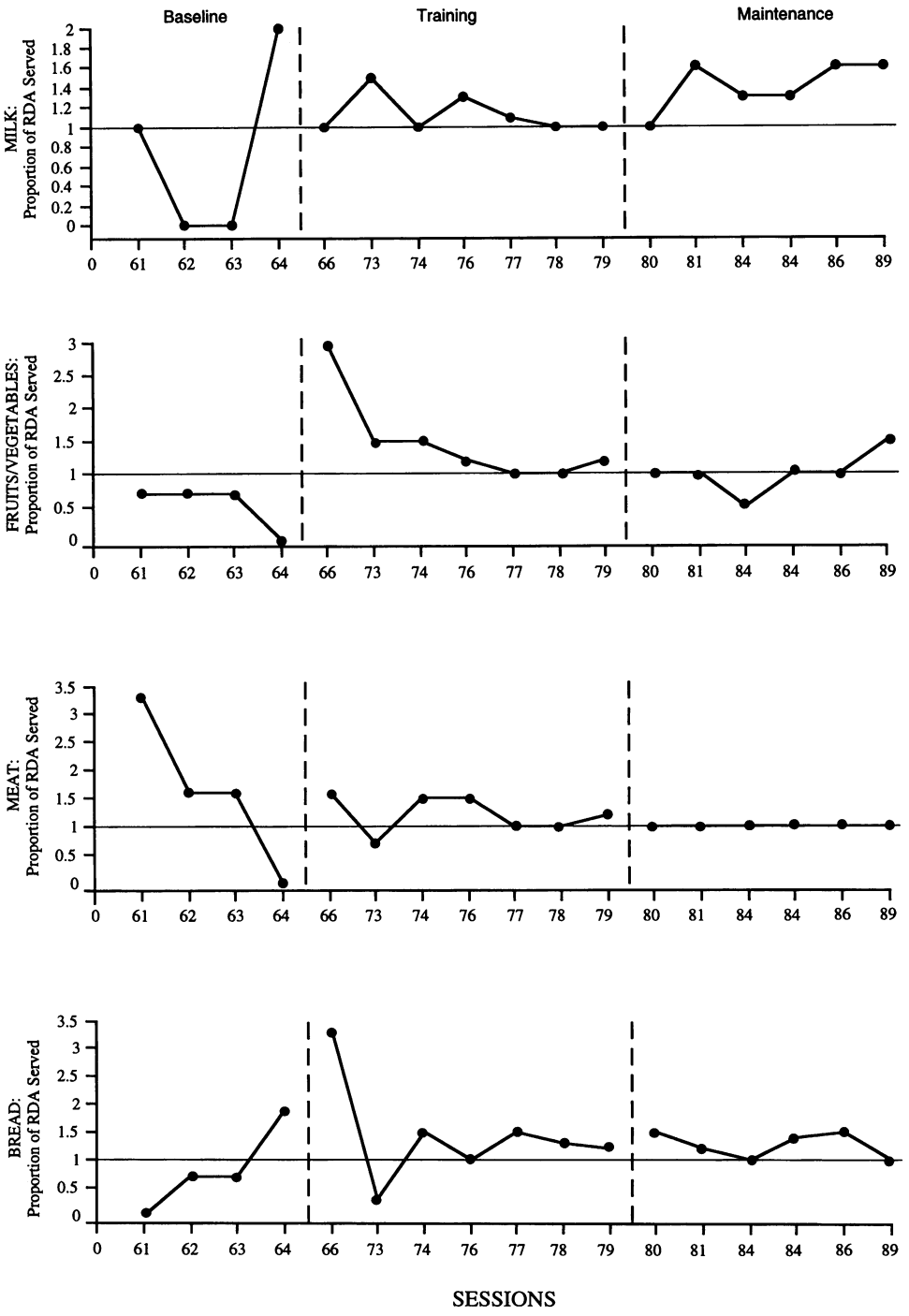

Figure 3. The proportion of the recommended daily allowance that Christine served to John during meals for which she was responsible for preparing. The horizontal lines indicate the RDA.

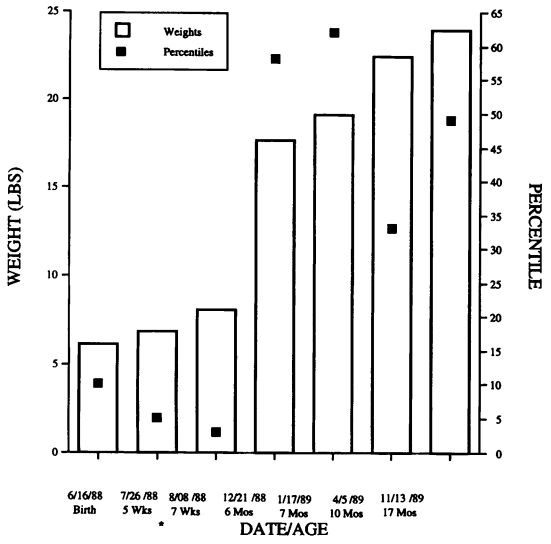

Figure 4. John's weight and its percentile rank at various ages during the course of service. The asterisk denotes the point at which 12-Ways services began.

service personnel, discussions with Tricia and Malcolm, and observations of them with the children. Services addressed the issues that DCFS had identified as concerns and obstacles to Tricia regaining custody and that seemed amenable to training. These included the condition of the home, providing adequate nutrition, Tricia's ability to supervise and manage the children, and her ability to protect them from Malcolm, who was described as volatile and inclined to verbally intimidate others.

Experimental Procedures

Standard training plus verbal negotiation. It was not clear whether the poor condition of the home and the fact that Tricia did not provide the children with a nutritious snack were due to a lack of skill or to other variables. Accordingly, we initially proceeded on the assumption that skill training was needed. Therefore, this condition was essentially the same as Christine's

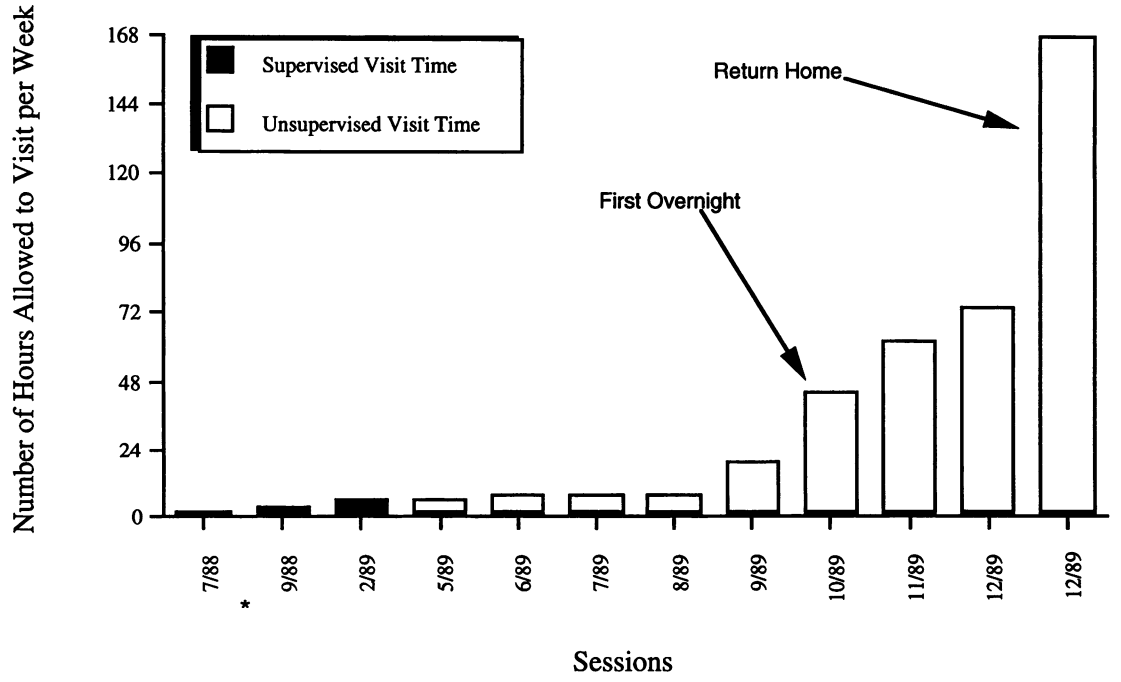

Figure 5. The number of hours of supervised and unsupervised time that were granted to Christine to spend with John over the course of service. Arrows indicate the point at which John spent his first night at her home and the point at which he was returned to her custody on a full-time basis. The asterisk denotes the point at which 12-Ways services began.

training condition described in Study 1. That is, at each session staff described and demonstrated a particular skill or task and provided feedback as Tricia or Malcolm performed the task. However, both were immediately able to perform many of the tasks (e.g., clean a counter top, praise the children during play) upon request. In addition, Tricia was able to describe food items that would be appropriate to prepare and to offer a plan for purchasing them within the constraints of her budget.

Therefore, in addition to training, during each session the staff member negotiated with the couple to complete by the next session certain tasks that were ultimately relevant to regaining custody of the children. These tasks typically focused upon preparing nutritious food for the children and improving the physical condition of the home (e.g., purchasing certain cleaning supplies, removing spider webs). Typically, two or three such tasks were negotiated for completion by the next session. When it became apparent that training and negotiation did not affect completion of these tasks, additional contingencies were devised.

Standard training plus written contract for increased visitation and restoration of custody. During this condition, standard training continued. In addition, a written behavioral contract was developed. Its purpose, stated in the contract itself, was to provide the couple "the opportunity to gain longer periods of visits with the children . . . until they can regain total custody." The terms of the contract specified that the couple would be expected to obtain and prepare food for a balanced meal for the children during visits and to complete other tasks negotiated on a weekly basis. The contract specified that if these criteria were met, the staff member would ask DCFS either to increase the weekly visiting time by 15 min or to allow a portion of the visiting time to occur privately, without supervision by staff or the child welfare agency.

Within this general framework, specific details were negotiated each week to accommodate both foreseen and unforeseen events. For example, efforts were made to extend visiting time on the very day that the couple completed the tasks. However, such changes occasionally had to wait until the earliest practical opportunity (typically, the next visit) in order to manage the logistics associated with changing the schedules of the foster parent, the caseworker's assistant (who provided transportation for the children), and the children themselves. Similarly, in the summer Janet had ample time available for visits, but by fall she began school at a great distance from the couple's home. Therefore, in lieu of an increase in overall visiting time, additional unsupervised time with the children was negotiated. Finally, both the child welfare agency and Project 12-Ways reserved the prerogative to modify or terminate the contract if unforeseen events placed the children at risk. One such event occurred in May of 1991 when Malcolm became verbally abusive toward a staff member. The contract was subsequently modified to state that such disruptions could result in immediate termination of the session and the return of the children to the foster home.

At the start of each session, the couple was asked to report whether the tasks had been completed as agreed. The staff member verified the report by visual inspection (e.g., to confirm the purchase of dish soap) and enthusiastically praised the couple when tasks had been completed. Then the next relevant task was negotiated, and the couple was instructed in and practiced its completion. The tasks that were agreed upon and the changes in visiting opportunities that would be allowed were written on the contract for both parties to sign.

Occasionally, the staff identified additional tasks (generalization tasks) that were relevant to the children's welfare but that were not made part of the written contract. These were comparable to contract tasks and, in fact, often were eventually incorporated into the contract. For example, a task incorporated into the written contract might have been to clean the kitchen sink, whereas a noncontractual task might have

been to clean the kitchen table. In the latter case, the staff member strongly recommended that the couple complete the task because it would improve conditions for the children and would probably have to be completed at some point. Including tasks relevant to the children's welfare but unaccompanied by written agreements or consequences provided a measure of the couple's generalized care of the children. As increases in visiting time (particularly unsupervised time) were earned, visits began to occur on weekends. The caseworker's assistant typically returned to the residence at about the midpoint of these weekend visits to check on the family's welfare.

Measurement and Reliability

The percentage of weekly negotiated tasks that were completed was the primary variable of interest. As in Study 1, performance was often measured (and reliability assessed) according to protocols reported in the literature (e.g., the Home Accident Prevention Inventory; Tertinger et al., 1984). Reliability was assessed between two trained observers on 25% of the sessions in all conditions. It averaged greater than 80%. Inasmuch as contract tasks involved simple, discrete events (e.g., purchasing dish soap), Tricia and Malcolm were asked to report whether the tasks had been completed. There were no instances of disagreement between their report and the staff member's observation.

Experimental Design

Services were delivered in a manner consistent with an A-B-A design: standard training plus verbal negotiation, standard training plus written contract, standard training plus verbal negotiation. The decision to return to standard training plus verbal negotiation was made after approximately 1.5 years of written contracts. During that period the couple had gained only as much as one 8-hr visit per week during waking hours. Completion of tasks had become erratic, and other events (including public disruptions and Malcolm's arrest) raised concerns about allowing greater visiting time, particularly if the couple continued to require special contingencies. Therefore, the written contract was removed, thereby providing an opportunity to determine whether the couple's completion of tasks pertinent to the children's welfare would be sustained without the special contingencies involved in the contract.

Results

Figure 6 indicates that during the period when the couple received standard training (of the sort that was effective in Study 1) and verbally agreed to complete relevant tasks, their actual completion of these tasks was 0%. The couple had already been granted supervised visits totaling 3 hr each week during this period. When greater visiting time was made contingent upon completing these tasks, a pronounced improvement occurred. However, a series of events (noted in Figure 6) probably contributed to erratic completion of tasks. These included the birth of Pete, Tricia's episode with depression, the couple's move to a new residence, and Malcolm's arrest and brief imprisonment when he and Tricia awoke neighbors during an argument outside of their home before dawn. When the standard training plus verbal agreement was reinstated, completion of tasks deteriorated further. On the last day of that condition, Malcolm refused to participate in any training, became verbally abusive of staff, and services were terminated.

Figure 7 depicts the couple's completion of contract and noncontract (generalization) tasks for the period during which the written contact was in effect. Very few tasks that were not specified in the contract were completed, although these were important to the children's welfare and were often eventually incorporated into subsequent contracts.

GENERAL DISCUSSION

The two families were a study in contrast. Christine gradually acquired and regularly ap-

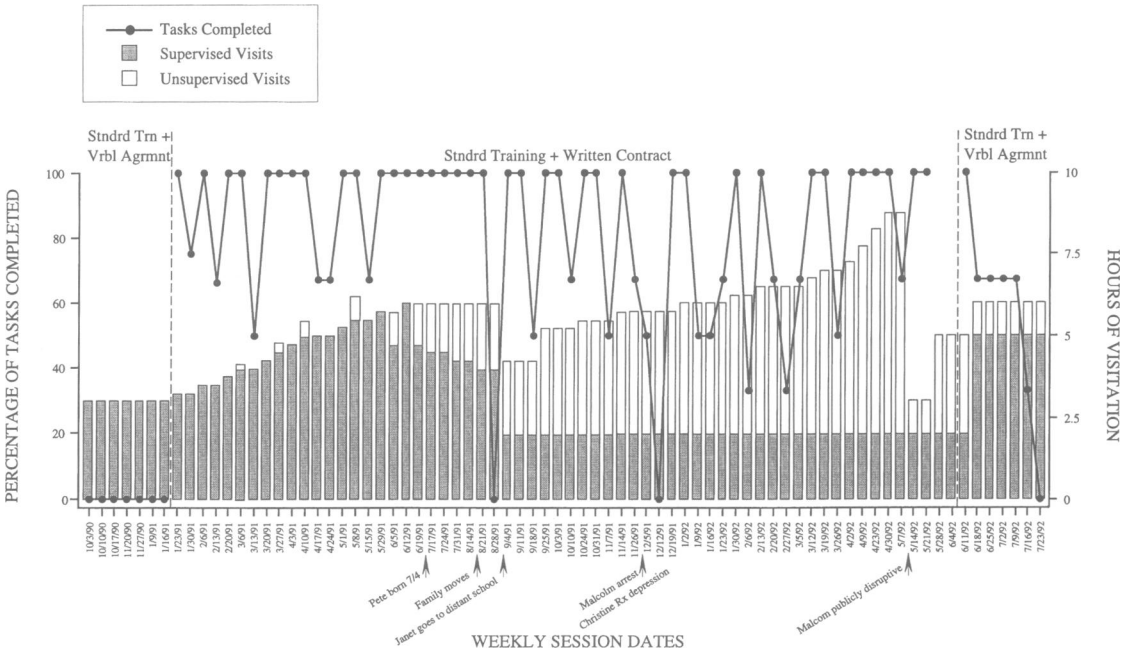

Figure 6. The percentage of tasks completed and the number of hours of weekly visiting time (supervised and unsupervised) during the course of service. Arrows indicate significant events. When Malcolm verbally threatened personnel at an early intervention program (last arrow), the child welfare agency suspended unsupervised visits.

plied essential parenting skills. Tricia (and Malcolm) often demonstrated their ability to perform skills, but applied them inconsistently. No unusual or dramatic contingencies were required to effect changes in Christine's performance; familiar instructional strategies were sufficient. Of Tricia, however, a caseworker once said that she "doesn't get the connection between making changes and getting her kids back." A contingency to establish that connection explicitly and precisely was applied that simultaneously provided a functional test of the reinforcing value of the children. That is, a fairly immediate and incremental restoration of the children's custody was made contingent upon improving some of the conditions that were obstacles to regaining full custody. The data in Figure 6, showing the failure of this rather "natural" contingency to sustain continual progress, and the data in Figure 7, showing that it effected very few generalized changes, ultimately became compelling evidence in the court's decision to terminate Tricia's parental rights.

In speculating about the difference in outcomes for the two families, several factors should be considered. First, Christine had not acquired a protracted history of unsuccessful child rearing. Services beginning shortly after John's birth established both a successful pattern of child care and the expectation that foster care was indeed temporary. Tricia's children were older and had become entrenched in foster care, which actually may have allowed Tricia to escape or avoid some of the demands of child rearing. Second, the parenting demands were different. Christine had one child, whereas Tricia had two and then three children to care for. Furthermore, although Malcolm purported to want custody of all the children, he may not have been completely supportive of Tricia in that regard, particularly after Pete's birth. Third, the parents in both cases were unemployed and, therefore, isolated from an important source of social contact. However, Christine frequently visited her own former foster parents and had other important social relationships that may

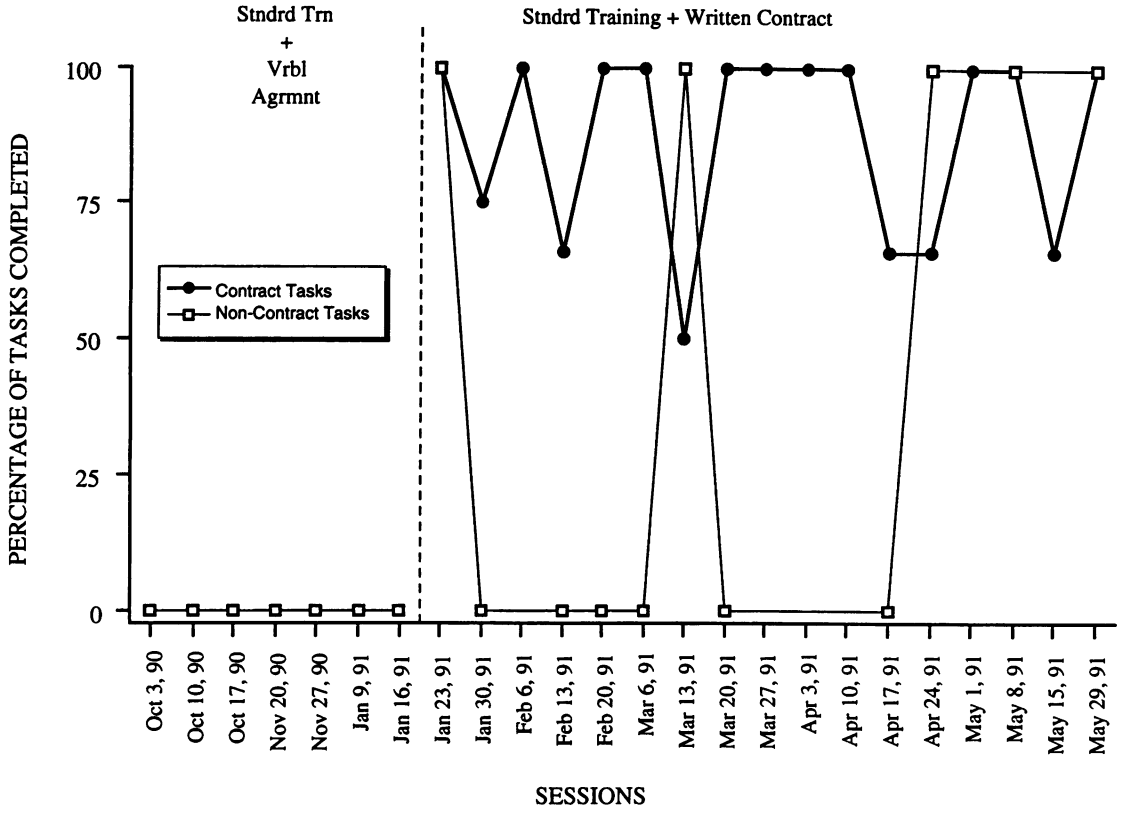

Figure 7. Completion of tasks that were included (closed circle) versus recommended but not included (open circle) in the written contract.

have served to support her parenting efforts. Tricia and Malcolm were very isolated. Their social contacts were virtually limited to service providers (Wahler, 1980). Fourth, Tricia's depression, Malcolm's public disturbances, and the couple's disputes may all have militated against the contingencies we developed to improve parenting.

These and other variables represent complex and pervasive obstacles to successful parenting in many cases (Lutzker et al., 1982; Maas & Engler, 1957; Tymchuk & Andron, 1990; Wahler & Fox, 1981). When these obstacles are not completely surmounted by treatment contingencies (e.g., behavioral contracts) or other efforts that courts acknowledge as "reasonable" to preserve families, then interesting questions of public policy and child welfare are raised. Specifically, on the one hand society generally recognizes the importance of maintaining continuity in children's relationships with adults, particularly parents, even in cases involving abuse or neglect. On the other hand, family law primarily views parents as fit or unfit, competent or incompetent. When parents are judged unfit or incompetent, their rights and responsibilities typically are terminated completely. That is, the relationship itself is dissolved. Therefore, if it is truly valuable to maintain important relationships between children and their parents, then public policy requires reformation to accommodate situations involving parents with limited competence. Such a policy might provide a continuum, at one end of which the parent would have full rights and responsibilities for the child. At the other end of that continuum, responsibilities for parenting might be distributed among informal and formal parties (e.g.,

extended family members, respite providers, foster parents).

Such an arrangement was nearly established in Tricia's case at one point when we were more optimistic about the prospects for reunification. At that time we foresaw a need for ongoing support in a form that would at least have provided Tricia's family with regular periods of respite, if not more extended involvement of foster care for the children. Such support was under discussion with DCFS before the case ended. Although we were unable to establish them in this case, the feasibility, advantages, and disadvantages of such supportive arrangements deserve careful study.

Research should also examine the kinds of assessment processes and information that could facilitate decision making in the resolution of child welfare cases. A central concern in such cases is to effect a permanent and stable living arrangement for the children; the assessment and analyses associated with the present two studies appeared to contribute to that end. Although it took nearly 2 years in both cases, a clear and final decision about the children's living arrangements was ultimately made, thereby avoiding the common problem of children drifting throughout the foster care system or between the biological and foster homes (Maas & Engler, 1957). Additional research may be helpful in considering assessment and intervention strategies to facilitate such decisions. For example, perhaps the prospects of the parent assuming full-time parenting responsibility should be questioned very early, and different intervention strategies should be attempted if the incremental custody of the children is made contingent upon the parent's completion of child care tasks but does not effect sustained and generalized changes in child care practices (see Figures 6 and 7).

Future research should also provide more careful, thorough, and precise descriptions of participants. In most of the research cited here, parents were described as mentally retarded when their IQs were actually above 70; therefore, they technically were not mentally retarded. The participants in the present study also did not meet the criteria for mental retardation, although they had been labeled as such throughout most of their lives. They had, however, met the eligibility criteria for disability services all their lives and, according to the federal definition, were developmentally disabled. The interpretation of studies in this growing area would be aided by more thorough descriptions of participants' personal histories that include their involvement with the child welfare system as children and adults, their work histories, and their network of formal and informal supports.

Finally, maltreatment of children is an age-old concern, revisited in the 1990s with questions about the competence of parents with disabilities and the scope and nature of efforts that society should reasonably make to preserve families. These are stark questions behavior analysts can address only in the context of actually serving families at imminent risk for dissolution. We have found that behavioral research in this context will often encounter enormous methodological challenges and controversial, sometimes divisive, ethical dilemmas.

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